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ABSTRACT

A subcommittee on terminology was formed to communicate with national groups of health educators, administrators, and clinicians to (a) identify terms which appear to be misused by "others," and (b) attempt to reach a consensus on logical and accurate meanings of key terms used in communicating about health careers education. Presented are 38 suggested definitions arranged in clusters of terms which are mutually dependent upon one another to clarify their meanings. Acronyms, initials, and certification and registration designations are listed. About one-third of the bulletin is devoted to information on recent actions of the American Medical Association House of Delegates concerning terminology. (SC)

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DRAFT COPY

(For Review and Comment)

INFORMATION BULLETIN

SUBCOMMITTEE ON TERMINOLOGY

of the

ADVISORY COMMITTEE ON EDUCATION FOR THE
ALLIED HEALTH PROFESSIONS AND SERVICES

AND ITS

PANEL OF CONSULTANTS

"THE LANGUAGE OF ALLIED MEDICAL EDUCATION"

January 1, 1974

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

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February 1974

Dear Reader:

This draft of the Subcommittee on Terminology Information Bulletin is to be viewed as a working document, subject to revision and improvement when readers such as yourself apprise the Subcommittee on Terminology of errors or misconceptions in the present draft.

Each of you is encouraged to study the accompanying information bulletin and to propose more cogent definitions or explanations for terms that relate to your field of activity. In addition you are invited to share with the Subcommittee information about terminology (related to allied health education) which appears particularly vexing to you.

We eagerly await your comments, criticisms and suggestions.

Sincerely,

Don Lehmkuhl, Ph.D.
Secretary, Subcommittee on Terminology

DL/bw

The Subcommittee on Termonology is a unit of the AMA Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services and its Panel of Consultants. Membership rosters follow.

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GLOSSARY OF TERMINOLOGY FOR THE ALLIED MEDICAL PROFESSIONS AND HEALTH OCCUPATIONS

An Introduction

Terminology related to education and practice in the large number of health occupations that have evolved during the last 50 years has become so varied and complex that communication between members of different health occupations often breaks down. When a given term has different meanings for different people, communication disintegrates and problems multiply.

We are faced with the serious problem of finding words which convey to others the ideas -- the concepts -- that these terms are intended to express. It has become common to find words that have more than one "correct" meaning -- correct in the sense that the user may have adopted a working definition of the term that causes it to mean what he wishes it to mean.

Most major health organizations and associations of practitioners have committees busily engaged in defining terms that have importance to them. Unfortunately, many of these committees are working in isolation and they sometimes come up with a definition that does not mesh well with that of a similar situation in a different health field.

It is our fervent hope that the forum provided by the Advisory Committee and its panel of Consultants can serve to bring some of the inconsistencies or misuses of terms in the related health occupations to light and that we can help formulate rational solutions to these problems.

Urban Eversole, M.D.
Chairman

HISTORY AND BACKGROUND OF SUBCOMMITTEE ON TERMINOLOGY

The Council on Medical Education's involvement in allied health education began in the mid-1930's when it entered into formal collaborative relationships with the American Occupational Therapy Association and the American Physical Therapy Association to separately accredit curriculums in occupational therapy and physical therapy. In the decades that followed, the breadth of the Council's involvement paralleled the growth of allied health in the U.S. -- today, the Council collaborates with twenty-eight allied health and medical specialty organizations for the approval of educational programs for twenty-four allied health occupations.

The Council's appreciation of the importance of allied health education can be best evidenced through review of the following developments:

The establishment, in 1967, of the Advisory Committee on Education for the Allied Health Professions and Services as one of four standing Committees of the Council. This nine-member committee meets four times yearly and considers matters concerning allied health on behalf of the Council, preparing recommendations for the Council's consideration. Current membership on the committee includes practicing physicians, medical educators, deans of allied health and nursing schools, a junior college president, and a hospital administrator.

The appointment, in 1969, of a Panel of Consultants to the Advisory Committee. This panel consists of one representative — appointed by and responsible to — each of the organizations collaborating with the Advisory Committee and Council, with a mechanism for two-way communication with the professional societies which is invaluable in considerations concerning policy and procedures. The Panel meets twice yearly with the Advisory Committee.

The authorization, in 1971, of nine Subcommittees of the Advisory Committee to consider subjects of general concern in allied health. Subcommittee membership is not restricted to members of the Advisory Committee and Panel of Consultants, further expanding the expertise of these groups. Members of the subcommittees participate as individuals rather than organizational representatives and may select their areas of interest.

One of the first problems faced by the Panel of Consultants to the Council on Medical Education's Advisory Committee on Education for the Allied Health Professions and Services when they held their organizational meeting in May 1968 was difficulty in communicating effectively with one another about allied health education and accreditation of educational programs. It was obvious that some participants were using a particular term to mean something different than other participants thought it should mean. Over the years, a significant degree of parochialism has developed among the various groups of persons educated and trained to provide special types of health care services which complement or supplement those services provided directly by physicians. Terms which originally meant something in a particular field have been adopted to mean something different in another field. When members of the different groups got together, misunderstanding, confusion and ill will sometimes resulted which can be attributed to "the other person's misuse of terms." It would be interesting to know how many times an emotional reaction was triggered in certain groups of non-physicians when they were called "paramedical" personnel by a physician addressing them. The physician undoubtedly used the term to pay them a compliment but some non-physicians took it as a sign of condescension or denigration.

PURPOSE

As a means of attacking the problem, a subcommittee on terminology was formed for the purpose of communicating with appropriate national groups of health educators, administrators and clinicians to (a) identify terms which appear to be misused by "others" and, (b) attempt to reach a consensus on logical and accurate meanings of key terms used in communication about health careers education. All of us realize that terminology is a difficult, complex subject which cannot be resolved by one group; nor, can it be resolved at one meeting of representatives from many groups. Some groups have developed definitions and a glossary of terms to suit their own needs, and when their usage of a term departs significantly

from that of most other groups, they too frequently adopt a stance of "you do it your way and we will do it ours!" However, we must progress toward general acceptance of terminology that can be applied to all health occupations and understood by those outside our own group.

The subcommittee perceives its role as an ongoing one to solicit points of view and disseminate proposed definitions to interested individuals and organizations. By requesting each respondent to provide supporting arguments for a particular point of view, it will be possible to become aware of valid objections to certain usages and use this information to develop a more suitable definition of the term, or, to suggest another term that would convey the intended meaning.

Every attempt is being made to involve appropriate groups in this process. In addition to input from each of the 28 collaborating organizations, contact has been established with the American Association of Community and Junior Colleges, American Hospital Association, American Society of Allied Health Professions, U.S. Department of Defense, U.S. Department of Health, Education and Welfare, U.S. Department of Labor, AMA Department of Health Manpower, National Commission on Accrediting and the commission undertaking the Study of Accreditation of Selected Health Educational Programs.

Those who have suggestions to offer concerning the terms which follow, or, comments about terms that are particularly troublesome to them are invited to send their comments to the Secretary of the Subcommittee on Terminology in care of the AMA Department of Allied Medical Professions and Services, 535 North Dearborn Street, Chicago, Illinois 60610.

SUGGESTED DEFINITIONS

The following terms are not arranged in alphabetical order. Instead, they are organized into clusters of terms which are mutually dependent upon one another to clarify their meanings. In some instances, additional explanation has been appended to the definition to clarify a point.

Therapy - a service or art involving the use of remedial agents..

Therapist - one who possesses the knowledge and professional skills necessary for the treatment of patients or clients.

Occupational titles provide a clue to differences in assignment but they do not necessarily reflect the amount of education a person must have before being permitted to perform the assignment. While most persons believe that educational preparation through the baccalaureate degree is the minimum needed to function in the therapist role, some significant exceptions exist at the present time (e.g., respiratory therapist). Rather than adopt an arbitrary distinction between "therapist" and "technician" on the basis of years of formal preparation, it seems preferable to distinguish between them on the basis of types of functions they perform. In addition,

it would be desirable to subclassify personnel within a given occupational category, such as therapist, on the basis of such factors as the degree of knowledge and skills required, degree of responsibility for independent action permitted, the complexity and variety of activities expected to be undertaken and the degree of responsibility for supervision of others. One suggestion is to establish guidelines which describe the boundaries of each level of complexity such as has been proposed for classifying employees of educational institutions by the National Center for Higher Education Manpower Systems (Western Interstate Commission for Higher Education, P. O. Drawer P, Boulder, Colorado 80302). Four levels or grades of complexity would probably suffice to cover the roles performed, and each level could conceivably be categorized on the basis of the education and experience needed to prepare an individual to competently function in the role. Some educational programs might be designed to prepare graduates to perform at the lowest level of complexity as a therapist. Others might prepare graduates for entry level positions of intermediate or high complexity. Through personal growth, an individual prepared at one level might advance to a position of greater responsibility and complexity.

Technician - a specialist in the technical details of a subject; one who has acquired the ability to perform the practical details of a complex task or set of tasks.

Technologist - one who specializes in the application of knowledge to practical and/or theoretical problems, including the development of new equipment and techniques.

Certification - the process by which a nongovernmental agency or association grants recognition to an individual who has met certain predetermined qualifications specified by that agency or association.

Licensure - the process by which an agency of government grants permission to persons meeting predetermined qualifications to engage in a given occupation and/or use a particular title; or, grants permission to institutions to perform specified functions.

Registration - the process by which qualified individuals are listed on an official roster maintained by a governmental or non-governmental agency.

Historically, this term has been used synonymously with the current definition of "certification". However, the term certification should be used when attesting to a certain level of professional competency; registration is more appropriately the process by which the certified or licensed individuals are listed on an official roster.

Health Services - the services available to the public for maintaining, restoring or improving the condition of being sound in body and mind.

Health is not only the absence of disease; it is also related to the components of education, housing, environmental control, transportation, civil rights and alleviation of poverty.

Medical Services - services provided to the individual for the maintenance and restoration of health and the prevention of disease.

Allied Medical Personnel - individuals who work under the general supervision or direction of a physician in providing medical services to members of the public while exercising independent judgment within their areas of competence.

Allied Health Personnel - category of personnel which includes professional and supporting workers in the fields of patient care, public health and health research who assist in the provision of health service.

Instruction - includes the activities dealing directly with the teaching of students and with improving the quality of teaching.

Teaching, the major aspect of instruction, may be provided for students in a classroom of an educational institution or in another location such as in a home or hospital; it may be provided by direct student-teacher interaction or through some other recognized medium such as television, radio, telephone and correspondence. The purpose of instruction is to enhance learning. One might consider that the curriculum is what is taught, and instruction is how it is taught.

Course (discrete) - an orderly series of instructional activities dealing with a subject, in which learning experiences are structured to accomplish the educational objectives established for the course. A structure in which each subject-matter area segment is taught as an entity without special effort at articulation or correlation with other subject-matter areas or segments.

Courses (correlated) - a structure in which two or more subject-matter areas or segments, taught during the same school term to many of the same students, are articulated in such a manner that the relationships of the subject-matter areas are made a part of the instruction without destroying the identity of the respective subject-matter areas. Any course or section with which a given course or section is correlated may be specified.

Curriculum - a set of courses offered by an educational institution or one of its branches. It is associated with planned interaction of students with the instructional content, instructional resources and instructional process for the attainment of predetermined educational objectives.

Program - a structure designed to provide students with the knowledge and skills needed to work in a specific job or to improve their competence in that job. It includes the curriculum as well as the administrative support required to implement the sequence of educational and skill-development experiences identified in the curriculum plan.

Unit - a single quantity regarded as a whole in calculation; a part of any instructional course focusing on a central theme and making use of resources from numerous areas and the students' own experience.

Skill - the ability to use one's knowledge effectively and readily in execution or performance; a learned power of doing a thing competently.

Affective - relating to, arising from, or influencing feelings or emotions.

Cognitive - to know, including both awareness and judgment.

Psychomotor - of or relating to muscular action believed to ensue from prior special conscious mental activity; purposeful motor action of one or more parts of the body.

Module - a unit of learning which deals with a specific topic or concept and may be used in one or more courses.

Basic Modules - instructional units that foster the development of affective, cognitive and psychomotor domains of human behavior which are common to essentially all persons successfully engaging in a particular field of activity, e.g., providing health-care services to the public.

Common Modules - instructional units that foster the development of affective, cognitive and psychomotor domains of human behavior which are common to persons successfully engaging in two or more special areas within a particular field of activity, e.g., physical therapy and occupational therapy.

Special Modules - instructional units that foster the development of affective, cognitive and psychomotor domains of human behavior which are peculiar to persons successfully engaging in one occupational category.

Clinical Education/Initial Directed Field Work - planned learning experiences assigned as an integral part of didactic courses for the purpose of initial and basic experiences in directed observation and participation in selected practical activities.

The student is confronted with individual cases or problems, the identification and solution of which involve the application of principles and theory under the guidance of an experienced teacher. In the early phase of clinical education or initial directed field work emphasis is on experiential learning as opposed to performance.

Clinical Experience/Field Work - that portion of an educational program during which the student is provided opportunities to apply academically acquired knowledge in a real work situation applicable to his or her field of preparation.

Students are scheduled to participate in planned activities during specific blocks of time. The emphasis is on gaining skill in performing the basic procedures used in the field and on dealing with a variety of situations that are likely to be encountered on the job. Supervision must be provided by qualified, competent personnel; students need and expect close supervision and guidance during the early phase of this activity, but, the supervision should become more remote as the student demonstrates an acceptable level of competence in handling the responsibilities assigned.

In general, a sharp distinction cannot be made between "education" and "experience" in relation to helping students develop competence in the practical aspects of their field of preparation. However, the word "education" is used to imply that the major focus is on gaining knowledge, skill and attitudes thru instruction; whereas, the word "experience" is used to imply that the major focus is on gaining these through direct participation in events. Of course, these events may be directed and learning of specific things is the expected outcome in both situations.

Practicum - an extended period of full-time experience (weeks or months) in professional practice during which the student tests and reconstructs the theory which he or she has learned and during which expertise is sought.

The minimum length of time is often specified by a credentialing agency but should be sufficient for the student to achieve the identified competencies for the practicum period. It provides an opportunity for the student to assume major responsibility for the full range of duties in a real health care situation under the guidance of qualified personnel from the educational institution and from the affiliating health care facility or agency. It presupposes the learning experiences included in all other professional studies; it is not a substitute for them. It is a more complete and concrete learning activity than laboratory and clinical education or directed field work. Practicum in most situations is a type of internship.

Element (of a task) - the smallest step into which it is practical to subdivide any work activity without analyzing separate motions, movements and mental process involved.

Task - one or more elements. A task is created whenever human effort, physical or mental, is exerted to accomplish a specific purpose. It is one of the distinct activities that constitute logical and necessary steps for the performance of work by the worker.

Position - a collection of tasks constituting the total work assignment of a single worker. There are as many positions as there are workers in the country.

Job - a group of positions which are identical with respect to their major or significant tasks and sufficiently alike to justify their being covered by a single analysis and description. There may be one or many persons employed in the same job.

Cluster - a number of similar entities collected or grouped closely together.

Cluster of Occupations - occupations in which a significant proportion of the tasks performed are similar enough to enable a given practitioner to do some of the work of another with very little additional preparation.

Occupations comprising the cluster are those requiring the largest number of common elements in such areas as equipment, communications, computations, materials, related information or processes, and cognitive and manipulative skills.

Occupational Competence - includes technical knowledge and skills, manipulative skills, communication skills, human relation skills, work habits, and the ability to solve problems, to think independently and to make judgments necessary for satisfactory employment in the occupation.

Career - an occupation for which one engages in special preparation and for which one seeks employment on a continuing basis.

Career Ladder - a sequence of promotional steps that link jobs which ideally should be related in the same job family.

The ladder concept permits an employee to build from his or her current education and experience in order to advance to the next step. It is most probable that promotional lines in career ladders are not achieved without provision of formal educational programs as well as any relevant on-the-job training.

Career Mobility - the availability of opportunities for individuals employed in a particular job to move without undue restrictions to:
1) a similar job available in a different geographical location (geographic mobility); 2) a job with increased responsibility within the same or similar setting (vertical mobility); or, 3) a job in a related occupation which requires similar knowledge and skills (lateral mobility).

RECENT ACTIONS OF THE AMA HOUSE OF DELEGATES CONCERNING TERMINOLOGY

For the information of those who may be interested, the following statements have been excerpted from the published "Proceedings of the House of Delegates". These selected statements relate to terminology of interest to allied health personnel and, having been formally adopted by the House of Delegates, they represent the policy of the American Medical Association.

TERMINOLOGY FOR HEALTH OCCUPATIONS

November 1970

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Council on Health Manpower has been concerned with the lack of uniform interpretation within the medical profession and elsewhere of such terms as "allied health sciences," "allied health professions," "ancillary services," "paramedical personnel" and others, and with the need for more meaningful terminology for health occupations for future use by the American Medical Association. The above-mentioned terms have in the past been used almost interchangeably by different groups to designate occupations ranging from a dentist to a nurse's aide.

Within the AMA, specific definitions of such terms have been relatively few in number. In 1926, the House of Delegates approved a report of its Judicial Council which defined "allied sciences" as applied to medicine as "those subdivisions of general science that are held by teaching institutions of standing and reputation conferring the degree of Doctor of Medicine to have a place in the professional education and training of a physician." Members of this defined group were those individuals possessing a Doctorate degree in Physiology, Bio-chemistry, Pharmacology, or other area of general science having special application to medical education. By implication, House of Delegates action in 1958 defined "paramedical personnel" as all personnel who assist and work under the supervision of physicians and not as independent agents. In June of 1969, the House defined "allied health professionals" in terms of their status in hospitals, as individuals who "exercise independent judgment within their areas of competence, provided that a member of the medical staff shall have the ultimate responsibility for patient care," and who "participate directly in the management of patients under the general supervision or direction of a member of the medical staff." Usage of these and other terms, however, has remained inconsistent and lacked uniformity from one group to another.

The justification for a more rational system of terminology are three-fold.

The first is the elementary need for a language -- specifically, for agreed upon designations for general occupational levels within the health field which identify the degree of independence and professional skill exercised in provision of personal health services at each level -- so that more meaningful dialogue can ensue between medicine and other health disciplines as to the roles and responsibilities of each. The Council has studied the accepted definitions of terms currently in use to designate workers in the health care field, and has also discussed possible criteria that would define more accurately differ-

ent levels of independence and professional skill exercised in the provision of patient care services. Among such criteria might be:

- (a) The degree to which a health worker is ethically and legally accountable to the patient;
- (b) The locus for evaluation of his competence -- whether his performance is susceptible to evaluation only by his professional peer group or by individuals at a higher level of training;
- (c) The locus for accreditation or approval of training programs for his occupation; and
- (d) the extent to which his services are provided under the direction or supervision of an individual at a higher level of training.

It is recognized that application of these or other criteria will not uniformly produce precise, mutually exclusive occupational levels in the health field; in many instances, differences will be those of degree rather than kind. Nor should they be intended to produce such rigid stratification or compartmentalization. The "institutionalization" of occupational categories would only obstruct the innovation, experimentation and occupational mobility which is vital if the health industry is to respond effectively to changing service needs.

In considering this subject, the Council learned that similar activity directed toward establishing a classification system for health manpower levels is being conducted by other national organizations, including the Association of Schools of Allied Health Professions and the American Association of Junior Colleges. To avoid duplication of effort and possible conflict in suggested terminology, the Council plans to coordinate activity with these and other groups involved before recommending definitions for general occupational levels within the health field.

A second compelling justification for improved terminology is the need for more precise data on health manpower supply from the standpoint of specific services available; data which differentiate between the functions and particular capabilities of, for example, the "Registered Nurse" in a coronary care unit, the R. N. in a home health agency and the R. N. administrator. Generation of such data, as a prerequisite for realistic planning to meet future health needs, will also require a better language. More precise designations must be developed between and within specific health occupations; designations which identify the differences in education and experience, sub-fields of the service, patient care and/or administrative functions performed, supervisory relationships and other variables. To permit full use of computer technology in processing such data, the language would ultimately be numerical rather than verbal. The Council encourages continued study by AMA in cooperation with other concerned groups of the feasibility of developing such discriminate terminology, adaptable to computer processing, for use in obtaining more precise data on health services available in this country.

A third and immediate need is for the elimination of obviously outdated terminology; specifically, the terms "ancillary" and "paramedical." Webster's

Third New International Dictionary (Unabridged) gives the following definitions of these terms:

Ancillary: Subordinate, subsidiary (the main factory and its _____ plants) : Supplementary (the need for _____ evidence)

Paramedical: Concerned with supplementing the work of medical personnel : having a secondary relation to medicine (technicians and pharmacists are _____ personnel)

Regardless of the appropriateness of these terms in some instances, their accepted connotations are understandably disturbing to many health disciplines who have come to merit an increasingly important role in delivery of care to the extent that they are more truly allied with rather than subordinate or secondary to medicine in providing health services.

As noted previously, more discriminate terminology for all types of health occupations is needed and the Council plans to continue its efforts in this direction.

As an immediate step, however, the Council and the Board of Trustees recommend:

That the terms "ancillary" and "paramedical" no longer be used in AMA statements, and that the term "allied" be used in their stead.

LICENSURE OF HEALTH OCCUPATIONS

November 1970

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Board of Trustees' Council on Health Manpower has been concerned for some time with the multiple issues and problems involved in present systems of official licensure for health occupations. This concern is shared by numerous other groups within and outside medicine. Early in 1970, the American Hospital Association established a Special Committee on Licensure of Health Personnel directed to study problems of occupational licensure and develop suggestions toward resolving these problems. A special meeting of this Committee with the Council's Committee on Certification, Registration and Licensure was held in July of 1970, to discuss common concerns in this subject and areas where co-operative effort might be helpful.

Current attempts to increase the supply of health services through more effective and innovative use of allied health workers have given rise to a number of paradoxes. On the one hand, there is an acknowledged need for growth in

numbers and stature of the allied health professions and occupations, with concomitant professional recognition and economic well-being; yet at the same time there is need to avoid the problems of overspecialization and fractionalization of services entailed by occupational licensure systems and the resultant controls on entry into occupations and scope of permissible functions. There is an obvious need to ensure patient safety through requirements that ensure use of adequately trained personnel -- but an equally pressing need for more flexible use of manpower to provide health services.

The limitations and inadequacies of governmental licensing mechanisms for health occupations have been extensively discussed and documented in the literature and in practice. The purpose of this report is to review briefly some of the acknowledged limitations, examine some of the suggested changes in or alternative approaches to licensing now under consideration or trial, and to recommend steps designed to resolve known shortcomings in the system. This report reflects in part the discussions held with the American Hospital Association Special Committee on Licensure of Health Personnel.

For clarification, a definition of the terms and control systems discussed follows this report.

I. LIMITATIONS OF OCCUPATIONAL LICENSURE

There seems to be a growing body of opinion that occupational licensure has outlived its usefulness as a method of assuring quality health care services. Originally developed as a tool to assure public protection when the states assumed responsibility for regulating health professions, licensure laws evolved before the explosion in scientific and technological knowledge witnessed in the past two decades. The current proliferation of health occupations seeking licensure and the demand for personnel to provide newly developed technical skills brings into question the effectiveness of licensure as a mechanism to assure public protection. Official licensure involves the establishment and enforcement of minimal standards for entering and remaining in the practice of an occupation subject to governmental regulation. The standards established by professional groups for the accreditation of training programs and the certification of competence in graduates of such programs are set at a higher level than those for licensure and are designed to achieve excellence. These professional groups work to build curricula, accredit educational and training programs and establish their own disciplinary procedures to maintain professional standards.

In addition, while current licensure systems stipulate educational and performance requirements for initial entry into an occupation, they provide no means for ensuring continuing competence of the licensee; nor, for a number of reasons, do periodic relicensure proposals appear to offer a practical mechanism for ensuring such continued competence.

Proliferation in mandatory occupational licensure laws tends to foster a "craft union" approach to health care, and may lead to unwarranted increases in costs of service. The effects of licensure on costs of health care have not been documented, and more complete cost data should be collected before conclusions are drawn. Analysis of increased hospital costs, however, offers some indication of the effect in terms of salary demands when there is legislative recognition of a given health occupation. In addition, if mandatory licensure trends continue in the present era of functional and knowledge specialization, the time may come when an individual will need four or five licenses to perform a limited service, with resulting underutilization of personnel, and concomitantly increased cost to the consumer.

Current occupational licensure laws tend to inhibit innovation in the education and use of allied health manpower, and restrict the avenues available for entry into or upward mobility in a health career. Licensure standards, as well as the educational prerequisites on which such standards are partly based, inevitably lag behind changing job requirements in any industry evolving as rapidly as that of health care. Irrelevant educational requirements become even more firmly entrenched and difficult to change when incorporated into licensure statutes. Present licensure laws for some allied health occupations restrict utilization of these individuals by indicating the kinds of tasks they may not perform or otherwise imposing limitations on their functions. Existing laws do not recognize the experience a health worker acquires, nor a desire for delegation of new responsibilities to the employee by the employer. Proliferation of occupational licensure laws patterned after existing ones would tend to freeze existing classes of allied health personnel into current utilization standards and lead to an unnecessary multiplication of officially recognized classes of allied health workers.

In addition, licensure statutes -- and, it should be noted, voluntary certification-registration mechanisms as well -- usually restrict entry into or advancement in a health career to those individuals completing accredited educational or training programs. Virtually no recognition in present systems is made of past job experience or unorthodox education in granting certification, licensure or advanced educational credit or job placement.

Licensure of an allied health worker does not, per se, protect the physician or institution employing that work from liability. Possession of a license or certificate by an allied health worker serves as evidence that the possessor has acquired the prescribed training, but as the legal record clearly shows, it is no guarantee against liability for negligence. Such licensure or certification does not relieve the physician or institutional employer of legal responsibility for consequences if he knows or should know that the licensed or certified assistant is, in fact, not competent to perform a particular function. With few exceptions, medical practice acts do not prohibit the physician from delegating similar functions to an unregistered or unlicensed assistant who is competent to perform the functions; nor do they relieve the physician or institutional employer of liability solely because only licensed employees are utilized.

II. EXISTING OR PROPOSED ALTERNATIVES

A. Peer Certification or Registration

Certification or registration of the health worker by a professional association of his peers is an alternative currently in existence which traditionally has been used by health occupations to assure professionalism. Such certification is based in the main upon completion of a training program accredited by the professional association in conjunction with other groups and upon successful performance in an examination. Standards for voluntary certification are higher than the minimal standards of licensure. A number of the shortcomings of occupational licensure, however, have also been attributed to voluntary certification and accreditation mechanisms as well. These include slowness in responding to changing service roles; lack of routes to certification or registration other than through completion of formal education programs; duplicative educational requirements; restriction of upward and lateral career mobility; and lack of a mechanism to assure continuing competence. The AMA, Association of Schools

of Allied Health Professions and National Commission on Accrediting are in the process of initiating a study of the entire structure of the voluntary accreditation process for training programs in allied health fields. The study will specifically address itself to issues concerning the relationships between accreditation, certification and licensure and needed mutual modifications in all three functions.

B. Uniform Licensure Code

A second alternative, originally proposed by the National Advisory Commission on Health Manpower, would be the development of a national uniform licensing code for each category of health manpower requiring licensure to practice. Proponents believe that such a uniform code would be preferable to the present legislative inconsistency among states and would facilitate geographic mobility for health care workers. Problems noted with this approach include a similar potential for restricting entry into a field, inapplicability of national standards to regional manpower needs and uses, reluctance of states to abrogate their licensing authority and the possibility that model codes or statutes might encourage additional proliferation in occupations licensed. Legislative proposals introduced recently -- S. 2753 (Javits) and S. 3596 (Yarborough) -- call for a national study of the problems of licensure, the development of uniform codes and other steps to alleviate current problems. S. 3586 specifically calls for the Secretary of Health, Education, and Welfare to prepare a report by July 1, 1971, identifying the major problems of licensure, certification or other credentialing mechanisms for health personnel, and recommending steps to resolve such problems.

C. Institutional and Independent Practitioner Licensing

Nathan Hershey, LL. B., and others have proposed the concept of state occupational licensure for independent practitioners such as physicians, osteopaths, podiatrists and dentists, to whom the public has direct access, and institutional licensure to control health care personnel who work in an institution. Dependent practitioners such as nurses, practical nurses, physical therapists, medical technologists and so forth, would be unlicensed per se but would be accountable to the employing institution or independent practitioner when working under their direction and supervision. The licensed institution or practitioner would be accountable in turn to a state agency for the quality of care provided and for the appropriate use of such manpower. This concept of employer accountability for personnel working under that employer's supervision or direction seems to be workable for the physician as well as for the health care institution. Problems may well arise, however, in attempting to apply this concept to the not inconsiderable number of allied health personnel employed neither by a physician nor a hospital. Included in this group would be individuals working in industry, home health agencies, school health program, rehabilitation centers, special camps, and the like, as well as those who are self-employed. There are also unresolved questions concerning the qualifications and ability of any state agency to undertake this licensure and surveillance responsibility, and the danger of perpetuating rather than reducing constraints on flexible and innovative use of manpower. A variation of this proposal would vest responsibility for approval of manpower utilization plans in voluntary rather than governmental state agencies, hopefully providing more flexibility in operation. Problems with this approach include the political feasibility of such a voluntary agency and the amount of authority it would be able to exert.

D. State Medical Board Registration

A fourth possibility would involve centralizing the approval of training programs and registration of graduates in the state medical examining boards. A state board, for example, might be authorized to approve training programs for emerging health occupations in that state on the basis of submission of the core curriculum, the apprenticeship and a description of the position on the health team that prospective trainees would serve. If the program had merit and a need for the skills could be shown, the program could be approved and graduates registered. If the program was approved when submitted and a need for individuals with the particular type of training diminished, the approval could be withdrawn without the need for legislative action. This system would prevent the proliferation of licensed occupations frozen into rigid classes, and might offer assurances comparable to licensure of the potential competence of the practitioners. This approach might be workable for new and emerging health occupations such as the "physician's assistant"; however, opposition could be expected from those health occupations with established credentialing mechanisms.

E. Increased Public Policy Representation on State Licensing Boards

Another proposal envisions modifications in the present licensure system rather than an alternative thereto. In general, the majority of members of state licensing boards are representatives of the occupational group being regulated. It has been proposed by some that inclusion of more public policy representation on such boards, reflecting the needs of consumers, other health care providers and educators as well as the occupational group concerned would ensure greater public accountability for board actions. While the majority of membership would still belong to the occupation concerned, the addition of members from other health professions and well qualified laymen is recommended in order to provide checks and balances, help alleviate some of the duplicative educational requirements and functions now characteristic of existing professions, and lessen the possibility of arbitrary board decisions on individual applicants. Implementing such a proposal may prove difficult, however, in terms of separating public policy and competence assessment functions on the individual boards. Possible resistance from the occupations concerned may be anticipated also. A variation of this approach proposes the appointment by the state legislature of a single public advisory committee to consult and provide advice to every licensing board on policy matters.

Other approaches currently under consideration would combine specified elements of the above five proposals; would call for specific guidelines for occupational licensure set at the state level, centralization of all occupational licensing in one state agency; or establishment of a national system of certification, with Federal support, to determine minimum qualifications for job related clusters of health occupations.

III. CONCLUSIONS AND RECOMMENDATIONS

As noted previously, limitations and shortcomings in present credentialing mechanisms for health professions and occupations are generally acknowledged. Some of these shortcomings appear to be susceptible immediately to correction while others may be only partially alleviated on a short-term basis through modifications in present credentialing systems.

To effect such immediate, short-term alleviations, the Council on Health Manpower and the Board recommend:

- (a) That state legislatures be urged to amend state medical practice acts to remove any barriers to increased delegation of tasks to allied health personnel by physicians.

Such an amendment might be phrased as follows: "Nothing in this article shall be so construed as to prohibit service rendered by a physician's trained assistant, a registered nurse, or a licensed practical nurse if such service is rendered under the supervision, control, and responsibility of a licensed physician."

The majority of existing state medical practice acts do not define the practice of medicine in terms of specific functions. However, the amendment of medical practice acts as suggested above would codify the physician's recognized right to delegate patient care functions to competent personnel consistent with the patient's welfare, as well as the delegatee's right to participate in the practice of medicine, and might serve to reassure and encourage physicians to innovate in the use of manpower.

- (b) That increased study be given to the feasibility of establishing educational equivalency measures and job performance tests as alternative routes to advanced educational placement, licensure or certification of health personnel.

As noted previously, one characteristic of most health personnel credentialing mechanisms is the requirement that an applicant for a licensure or certification examination be a graduate of an accredited educational program. Such a requirement, while intended to ensure that each individual has the basic knowledge and skills needed, restricts entry to the graduates of a formal education program designed specifically for that occupation. For occupations now licensed or certified, state statutory or voluntary certification requirement revisions to grant advanced educational or job placement to individuals possessing previous educational or work experience equivalent to that required in an accredited program should be explored and encouraged where feasible. Accredited training programs could grant advanced educational placement based on similar criteria.

- (c) That encouragement be given to programs for periodically updating the knowledge and skills of currently licensed or certified occupations, utilizing such methods as continuing education courses, self-assessment tests and review mechanisms.

Encouragement has already been given by the House of Delegates to programs for maintaining continued physician competence, including continuing education and peer review, and to incentives for participation in such programs developed and implemented by the medical profession itself. Similar activity should be encouraged for other health professions and occupations.

It is apparent not only that drawbacks exist with present credentialing systems for health manpower, but that proposed alternative mechanisms need further in-depth study as well, so as to identify and resolve potential problem areas and develop a workable overall approach either incorporating the best features of each or substituting an entirely different mechanism. Mention has already been made of study activity currently underway by AMA, the Association of Schools of Allied Health Professions, and the National Commission on Accrediting, and in various sectors of the Federal government; other groups at both national and state level are studying specific aspects of the problem. Many of these efforts, however, are proceeding independently. At the same time, movement toward licensure for additional health occupations in the various states has in no way abated; in fact it has increased. Licensure has been or is currently being sought in one or more states by over 20 different health occupations. The Council believes, and the Board concurs, that this trend toward proliferation in classes of occupations licensed will in the long run work to the detriment of the health care employee by limiting his career opportunities, of the employer by impeding flexible and efficient use of manpower, of the educator by necessitating the offering of many separate yet overlapping curriculums, and of the patient by increased costs and fragmentation of services.

In order to forestall perpetuating a system of narrowly defined, legally circumscribed health service roles and permit time for coordinated development of practical alternatives, the Council and the Board recommend:

- (d) That the House of Delegates call for a nationwide moratorium on licensure of any additional health occupations, and that the American Hospital Association and the American Public Health Association be encouraged to join in supporting such a moratorium.

This would essentially be a request for a holding action on licensure by the states of additional manpower categories until long-range solutions are developed, and would not preclude amendment of existing licensure laws to permit expanded functions, authorize the functioning of new types of workers or increase access to licensure or certification for those with other than traditional prerequisites

- (e) That this report and the call for a moratorium be widely distributed to state medical, hospital and other professional associations, state legislatures and licensing boards, educators, employers and concerned federal government agencies.

DEFINITION OF THE WORD "PHYSICIAN"

June 1972

HOUSE ACTION: ADOPTED

The World Health Organization, at its Twenty-Fifth Assembly in May, plans to consider a definition of the word "physician" which reads as follows:

"A physician is a person who, having been regularly admitted to a medical school, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in medicine and has acquired the requisite qualifications to be legally licensed to practice medicine (comprising prevention, diagnosis, treatment and rehabilitation), using independent judgment, to promote community and individual health."

The Council of the World Medical Association has requested that the WHO delay action on its proposed definition and is recommending that the WMA set forth its own definition.

The Board of Trustees, after considering both the WHO and WMA definitions, recommends that the House of Delegates approve the following definition of the word "physician":

"A physician is a person who, having been regularly admitted to a medical school duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in medicine and has acquired the requisite qualifications to be legally licensed to practice medicine."

WORKING DEFINITION OF PHYSICIAN'S ASSISTANT

November 1970

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Board of Trustees and its Council on Health Manpower recommend that the following be adopted as a working definition of the term "physician's assistant" or any other term that indicates a new health occupation with qualifications other than those of a licensed physician working in the capacity of an assistant to such a physician:

The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.

PRIMARY PHYSICIAN'S ASSISTANT (GENERALIST)

November 1971

HOUSE ACTION: ADOPTED

At the 1971 Annual Convention, Report B of the Board of Trustees on the evaluation of the primary physician's assistant (generalist) was filed with the request that the Board reassess its choice of the term generalist in the title of these assistants.

The Board and the Council on Health Manpower have since learned that the Advisory Committee on Education for the Allied Health Professions and Services of the Council on Medical Education, in developing educational Essentials for these assistants, has adopted the term "Assistant to the Primary Care Physician."

This term is acceptable to both the Board and its Council.

RECOMMENDED DEFINITION OF THE ROLE OF A PRIMARY CARE PHYSICIAN

November 1972

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Board of Trustees and the Council on Health Manpower believe that a clear definition of primary medical care is needed in order to identify all those practitioners who may act as primary care physicians in serving as the point of access to primary care in specified situations. The Council and Board believe that problems of access to health care cannot be completely resolved simply by encouraging all individual citizens to have a family physician; also needed is a better public awareness that various other specialists actually function in providing primary medical care.

As a first step toward this goal, the Board and the Council recommend that the following be adopted as a definition of the role of a primary care physician:

A physician assumes the role of a primary care physician when the patient depends on him for the initial access to and for the provision and overall management of his medical care. The same physician may not invariably continue in this role, but, by referral, another physician may assume it. In any specific health matter, the particular physician who accepts a patient for primary care should assume continuing supervision of that care.

This relationship may also be carried out by a group of physicians who function in a defined, responsible pattern of medical practice. In such a type of practice a single physician, however, should maintain an ongoing relationship with the patient and coordinate his care.

PROGRAM FOR NATIONAL CERTIFICATION OF THE ASSISTANT
TO THE PRIMARY CARE PHYSICIAN

November 1971

HOUSE ACTION: FOLLOWING RECOMMENDATION CONTAINED IN REPORT B ADOPTED
AND REMAINDER OF REPORT FILED:

It is recommended that the AMA, through its Council on Health Manpower, assume a leadership role in developing and sponsoring a national program for certification of the assistant to the primary care physician who functions at the highest level of responsibility described by the National Academy of Sciences as a "Type A" assistant.

FOLLOWING RECOMMENDATION RE REPORT B ALSO ADOPTED:

That a national certification program not operate to eliminate existing and traditionally acceptable situations where an individual physician delegates to an employee certain duties for which he has trained that employee; that the body assigned to administer a certification program be named a registry rather than a board; that the composition of the Certifying Registry emphasize representation of practicing physicians and individuals knowledgeable in certification programs; and that, when state legislative bills authorizing physician assistants to the primary care physician are considered, the statement should be included that the primary care physician should at all times be in the active clinical practice of medicine.

The Council on Health Manpower recently reviewed a proposal for a National AMA Program to Certify the Assistant to the Primary Care Physician. The Council agreed that such a program which would grant certification on the basis of nationally validated examinations to individuals of both traditional and unorthodox educational background would help to ensure orderly development of the physician's assistant concept under medical guidance and thereby help assure the maintenance of high standards in the occupation.

The subcommittee of the Advisory Committee on Education for the Allied Health Professions and Services which will draft Essentials of an Approved Educational Program for the Assistant to the Primary Care Physician discussed the need for and importance of some type of certification as a complement to accreditation, and agreed to support AMA efforts toward development, in collaboration with other appropriate medical organizations, of national certification for Assistants to the Primary Care Physician.

The Board of Trustees approved development of such a program, with appropriate input from other organizations, and submits the following proposal to the House of Delegates:

PROGRAM FOR NATIONAL CERTIFICATION OF THE
ASSISTANT TO THE PRIMARY CARE PHYSICIAN

Background

The terms accreditation and certification are often used interchangeably and are closely related yet different in purpose and procedure. For this reason, definition of the two processes is appropriate.

Broadly speaking, accreditation is a form of regulation or control exercised over educational institutions and specialized programs by external organizations or agencies. The U. S. Office of Education defines accrediting as the "process whereby an association or agency grants public recognition to a school, institute, college, university, or specialized program of study having met certain established evaluation." One of the distinctive features of American education is that the development and maintenance of educational standards have traditionally been the responsibility of non-governmental, voluntary accrediting agencies.

Whereas accreditation relates to the evaluation and approval of an educational institution or program, certification refers to an evaluation of persons meeting qualifications specified by the professional association for the occupation and is primarily concerned with the competency of individuals to function on the job. Like accreditation, certification is largely carried out on a national voluntary basis by professional organizations and agencies.

Licensure may be viewed as a form of certification but one that is unique in that it (a) involves government, (b) is not optional or voluntary, (c) is usually administered at state level, and (d) usually regulates or offers a vehicle for the regulation of the activities of the occupation being licensed.

Depending on the particular profession or occupation being considered, the certifying function might rest with the professional association as in the case of the dietitians, medical record librarians, occupational therapists and dental assistants. On the other hand, certifying agencies may be set up independent of the profession being regulated though the profession may have representation in the agency. Examples include the Board of Registry of Medical Technologists, American Registry of Inhalation Therapists and the American Registry of Radiologic Technologists.

Individuals who meet certain requirements of education, experience and competency, and who successfully complete the examination given by the certifying body, usually are accorded use of special professional designations. Certifying organizations usually maintain lists of all persons certified by them. These lists of qualified personnel may be published by either the professional organization representing the particular occupation or by the independent registry or certifying authority.

In most health occupations, an applicant must meet three different requirements in order to be certified. The first of these is submission of proof of graduation from an approved educational program coupled with some clinical or practical experience. The second is the successful completion of a written examination administered by the certifying agency itself or by an outside testing agency. Membership in the professional association is sometimes a third requirement for certification.

Today there are more than 200 occupations concerned with patient care, community health and environmental health that fall within the conceptual framework of allied health. At the present time the AMA is involved in accrediting educational programs for various levels in ten of these occupations.

The American Medical Association in December 1970 recommended adoption of the following working definition of the term "physician's assistant":

"The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant."

In an attempt to further clarify supervisory relationships between the physician and physician's assistant, the House of Delegates adopted a report in June 1971 opposing use of the term "physician's associate" to designate a new occupation, since "associate" normally implies another physician.

The mission of a physician's assistant is to provide, under the direction and supervision of a licensed physician, selected diagnostic and therapeutic tasks, thus permitting the physician to extend his services to a greater population base through the more efficient use of his knowledge, skills and abilities. For example, the assistant to the primary care physician works closely with and under the direction and supervision of a physician who functions as the source of primary care to his patients (family practitioner, internist, pediatrician). Some of the proposed duties of the assistant to the primary care physician include functions now being performed by physicians.

The assistant to the primary physician is concerned with patients in all medical care settings (the office, the ambulatory clinic, the hospital, the patient's home, the extended care facility and the nursing home). His work is done under the supervision of a physician who retains responsibility for patient care, although the physician need not be physically present at each activity of the assistant nor be specifically consulted before each delegated task is performed. In addition to the execution of standing orders and routine patient care, these tasks include such other diagnostic and therapeutic procedures as the physician may assign to the assistant after he has demonstrated his proficiency and competency.

The primary physician serves as the point of primary contact and is responsible for the management of the total and continuing health care of the patient, rather than limited or episodic care. The physician's assistant will be involved with helping the physician in the total health care of the patient, the elements of which include diagnostic services, continuing medical care, minor illness and injury, major illness and injury, rehabilitation, health maintenance, and community health.

The best safeguard against incurring liability for the acts of allied medical personnel under a physician's supervision is for him to employ only persons who are competent to perform and carry out the responsibilities that are delegated and to make certain that they do not perform procedures that are beyond their competency. Licensure of allied medical workers does not relieve the physician of responsibility for the negligent acts or omissions of his assistant while functioning under this supervision. Nor does the responsibility of the physician, inherent in his position in the health care situation, absolve the allied health professional of all legal responsibility.

In the fall of 1970, both the AMA and the American Hospital Association issued statements recommending a temporary moratorium on the licensure of additional health occupations and are currently collaborating in establishing a National Commission for the study of licensure for the allied health occupations. The moratorium, however, applies primarily to licensure and does not preclude certifying activities on the part of either of the two sponsoring organizations. Recently in a report on licensure to Congress, the Secretary of the Department of Health, Education, and Welfare recommended a two year moratorium on the licensure of additional health occupations.

Reasons for Physician's Assistant Certification

The following specific reasons argue the need for some form of certification:

1. Programs for training physician support personnel under the rubric of "physician's assistants" are springing up everywhere. Few programs are alike -- they range anywhere from twelve weeks to five years in duration. Essentials for the Assistant to the Primary Care Physician are in the process of being

PHYSICIANS' ASSISTANTS

June 1972
HOUSE ACTION: ADOPTED AS FOLLOWS AND REFERRED TO
COUNCIL ON HEALTH MANPOWER

RESOLVED, That the House of Delegates of the American Medical Association go on record as favoring the use of physicians' assistants by primary physicians as adjuncts to individual practice where the use of such assistants will greatly increase the availability and quality of medical care; and be it further

RESOLVED, That the House of Delegates further states its approval of the use of pediatric, urological and orthopedic assistants and other specialty assistants trained under guidelines by their respective specialties; and be it further

RESOLVED, That the House of Delegates encourage other specialty groups to survey their membership to determine the need for physician assistants in their specialty and, if such need is demonstrated, to follow the guidelines laid down by the House of Delegates in establishing training programs for them; and be it further

RESOLVED, That the House of Delegates encourages the passage of legislation at the state level which would place control of the physicians' assistants and physicians utilizing such services under the control of state boards of physician licensing.

EMPLOYMENT OF PHYSICIANS' ASSISTANTS

June 1972

HOUSE ACTION: ADOPTED AS FOLLOWS:

The Council on Health Manpower has for some time been concerned with the potential problems which could arise from the employment of physicians' assistants by hospitals. The Council believes that direct responsibility to and supervision by a physician is a critical element in the safe and effective performance of a physician's assistant. Concern with this subject has also been evidenced by the American Hospital Association which, in November 1970, approved a statement specifying that when a person having the qualifications of a physician's assistant is employed by a hospital, he is not then acting in the role of a physician's assistant.

The Council on Health Manpower's "Working Definition of a Physician's Assistant," adopted by the House of Delegates in November 1970, favors close supervision of the physician's assistant by a physician but does not explicitly oppose employment of a physician's assistant in that capacity by a hospital.

The Board of Trustees and its Council on Health Manpower recommend that it be the policy of the American Medical Association that a physician's assistant not function in that capacity when an employee of and paid by a hospital or by a full-time salaried hospital-based physician.

STATUS AND UTILIZATION OF NEW OR EXPANDING HEALTH PROFESSIONAL IN HOSPITALS

June 1973

HOUSE ACTION: ADOPTED AS FOLLOWS:

The past few years have seen an increased trend toward development of new health occupations designed to assist the physician in patient care. There also have been efforts to prepare members of established health professions, such as nursing, to assume expanded medical support roles to the physician in providing medical care. To assist the medical staff in regulating the activities of such emerging or expanding health professions in hospitals, the following statement has been prepared by the Board of Trustees, its Council on Health Manpower and Committee on Nursing, and is submitted to the House of Delegates. While similar in some respects to "Medical Staff Membership and the Status of Allied Health Professionals in Hospitals," adopted by the AMA House of Delegates in June 1969, this statement is directed toward the functioning of a different group of individuals and is designed to complement the 1969 report, not to replace it.

1. The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below:

- a. As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care.
- b. They participate in the management of patients under the direct supervision or direction of a member of the medical staff, who is responsible for the patient's care.
- c. They make entries on patients' records, including progress note forms, only to the extent established by the medical staff.

Thus this statement covers regulation of such categories as the new physician-support occupations generically termed "physician's assistants," and those allied health professionals and nurses functioning in an expanded medical support role. It is not intended to cover regulation of nurses and allied health professionals performing in their regular and customary roles, nor nurse practitioners functioning within the legal definition of nursing.

2. The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws:

- a. Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as for medical staff membership and privileges.
- b. The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant.
- c. In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions.

MEDICAL SCHOOL ADMISSIONS

June 1973

HOUSE ACTION: ADOPTED AS FOLLOWS:

RESOLVED, That the American Medical Association go on record as favoring a greater use of non-cognitive selection criteria in the admissions process, criteria which will measure a student's motivation, social awareness and ability to communicate with others; and be it further

RESOLVED, That the American Medical Association promote the expansion of admissions committees at medical schools to include individuals qualified to assess such criteria; and be it further

RESOLVED, That the American Medical Association inform the Association of American Medical Colleges of its belief that the Medical College Admissions Test (MCAT) should be revised so as to eliminate such questions as may be culturally biased, and to include sections which measure, where possible, the sorts of non-cognitive criteria which admissions committees may find useful.

PEER REVIEW - GLOSSARY OF TERMS

November 1971

HOUSE ACTION: ADOPTED AS FOLLOWS:

Peer Review: evaluation by practicing physicians of the quality and efficiency of services ordered or performed by other practicing physicians. Peer review is the all-inclusive term for medical review efforts. Medical practice analysis; inpatient hospital and extended care facility utilization review; medical audit; ambulatory care review; and claims review are all aspects of peer review.
(adopted June 1971)

Medical Practice Analysis: a function of the medical society, or other organization authorized by the medical society, designed to coordinate all peer review efforts of a community. Medical practice analysis focuses on the development and application of criteria for optimal medical care, and evaluates the individual and collective quality, volume and cost of medical care, wherever provided.
(adopted June 1971)

Institutional Care Evaluation: peer review to assure the quality of medical care provided within a health care institution.

A function of the medical staff incorporating the concepts of utilization review and medical audit.

Ambulatory Care Evaluation: peer review to assure the quality of medical care, services, and procedures provided to ambulatory patients.

A function of the local medical society, or other organization authorized by the medical society, in a geographically defined locality, which incorporates the concepts of utilization review and medical audit.

Utilization Review: evaluation of the efficient use of professional medical care services, procedures, and facilities.

As a function of the institutional medical staff, utilization review would include analysis of the appropriateness of: admissions, services ordered and provided, length of stay and discharge practices, and documentation, both on a current and retrospective basis.

As a function of the local medical society, or other organization authorized by the medical society, utilization review would focus on the appropriateness of diagnostic procedures, therapy, and documentation.

Medical Audit: retrospective examination of the clinical application of medical knowledge, advancing the level of medical care in an institution or in a community through an educational process.

Claims Review: peer evaluation and adjudication of claims questions referred for peer review by any party with a valid interest in the case. (adopted June 1971)

ACRONYMS AND INITIALS OF SELECTED ORGANIZATIONS, GROUPS AND PROJECTS

ORGANIZATIONS/ELEMENTS CONCERNED WITH ALLIED HEALTH EDUCATION

AABB	- American Association of Blood Banks
AACJC	- American Association of Community and Junior Colleges
AAFP	- American Academy of Family Physicians
AAMA	- American Association of Medical Assistants
AAMC	- Association of American Medical Colleges
AAOS	- American Academy of Orthopaedic Surgeons
AAP	- American Academy of Pediatrics
AART	- American Association for Respiratory Therapy
AASCU	- American Association of State Colleges and Universities
ABMS	- American Board of Medical Specialties
ACCP	- American College of Chest Physicians
ACP	- American College of Physicians
ACR	- American College of Radiology
ACS	- American College of Surgeons
ADA	- American Dental Association
AES	- American Electroencephalographic Society
AHA	- American Hospital Association
AHME	- Association for Hospital Medical Education
AMA	- American Medical Association
AMEA	- American Medical Electroencephalographic Association
ANA	- American Nurses Association
AOA	- American Optometric Association
AORN	- Association of Operating Room Nurses
AORT	- Association of Operating Room Technicians
AOTA	- American Occupational Therapy Association
APTA	- American Physical Therapy Association
ASA	- American Society of Anesthesiologists
ASAHP	- American Society of Allied Health Professions (formerly Association of Schools of Allied Health Professions)
ASCP	- American Society of Clinical Pathologists
ASET	- American Society of Electroencephalographic Technologists
ASIM	- American Society of Internal Medicine
ASMT	- American Society for Medical Technology
ASRT	- American Society of Radiologic Technologists
ATS	- American Thoracic Society
AUA	- American Urological Association
CCME	- Coordinating Council on Medical Education
CIHP	- Coalition of Independent Health Professions
CME	- Council on Medical Education
CMSS	- Council on Medical Specialty Societies
FED	- Federal Government - Representation
FRACHE	- Federation of Regional Accrediting Commissions of Higher Education
JCAH	- Joint Commission on Accreditation of Hospitals
LCCME	- Liaison Committee on Continuing Medical Education
LCGME	- Liaison Committee on Graduate Medical Education
LCME	- Liaison Committee on Medical Education (undergraduate)
NATTS	- National Association of Trade and Technical Schools
NCA	- National Commission on Accrediting
NHC	- National Health Council
NLN	- National League for Nursing
NMA	- National Medical Association
PUB	- Public - Lay Representation
USOE	- U. S. Office of Education
SNM	- Society of Nuclear Medicine
SNMT	- Society of Nuclear Medicine Technologists

CERTIFICATION AND REGISTRATION DESIGNATIONS

ART	- Registered Accredited Medical Record Technician American Medical Record Association
ARIT	- Registered Inhalation Therapist (Respiratory Therapist) American Registry of Inhalation Therapist, Inc.
CMA	- Certified Medical Assistant American Association of Medical Assistants
CLA(ASCP)	- Certified Laboratory Assistant Registry for Medical Technologists American Society of Clinical Pathologists
COTA	- Certified Occupational Therapy Assistant American Occupational Therapy Association
CORT	- Certified Operating Room Technician Association of Operating Room Technician
CRTT	- Certified Respiratory Therapy Technician American Association for Respiratory Therapy
CT(ASCP)	- Registered Cytotechnologist Registry for Medical Technologists American Society of Clinical Pathologists
HT(ASCP)	- Registered Histologic Technologist Registry for Medical Technologists American Society of Clinical Pathologists
LPN	- Licensed Practical Nurse State licensing board
MD	- Medical Doctor State licensing board
MT(ASCP)	- Registered Medical Technologist Registry for Medical Technologists American Society of Clinical Pathologists
MT(ASCP)BB	- Registered Specialist in Blood Banking Technology Registry for Medical Technologists American Society of Clinical Pathologists
MT(ASCP)NMT	- Registered Nuclear Medicine Technologist Registry for Medical Technologist American Society of Clinical Pathologists

- OTR - Registered Occupational Therapist
 American Occupational Therapy Association
- PT - Licensed Physical Therapist
 State licensing board
- RN - Licensed (Registered) Nurse
 State licensing board
- RPT - Registered Physical Therapist
 American Registry of Physical Therapists
 American Congress of Physical Medicine and
 Rehabilitation
 (No new persons added to registry after
 December 1971)
- RRA - Registered Medical Record Administrator
 American Medical Record Association
- RT (ARRT) - Registered Radiologic Technologist
 American Registry of Radiologic Technologists

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